Ministry of Health Ministère de la Santé

Ontario

Questions and Answers

THE *HEALTH CARE CONSENT ACT, 1996*

WHY A NEW CONSENT ACT?

What prompted the Government to repeal the *Consent to Treatment Act, 1992 (CTA)* and replace it with the *Health Care Consent Act, 1996 (HCCA)*?

In July 1995, the government announced it would repeal the *Advocacy Act, 1992* and that the *Consent to Treatment Act, 1992* and the *Substitute Decisions Act, 1992* would be reviewed.

The purpose of the review of the CTA was to address concerns that were being expressed primarily by health practitioners that the CTA was too complex and bureaucratic, created adversarial barriers between health care providers and families and caused unnecessary delays in the treatment of mentally incapable people.

What major changes are made with the HCCA?

The HCCA does not require formal notices and meetings with rights advisers for findings of incapacity.

Health practitioners are required to follow guidelines established by their governing bodies as to the information which is to be provided to their patients about the consequences of findings of treatment incapacity.

The Act applies to fewer types of treatment.

It gives a health practitioner the ability to "opt in" to the provisions of the Act for certain things excluded from the definition of treatment.

It streamlines the process for substitute decision making for treatment of incapable people and the review process for people who decide to dispute a finding of incapacity.

It enhances the role of families in making decisions on behalf of their incapable relatives.

It allows a health practitioner to apply to the review board if he or she thinks that a substitute decision maker who gave or refused consent did not follow the rules for making substitute decisions.

The Act removes the prohibition on substitute consent to faradic stimulation (electric shock) as aversive conditioning.

It adds a substitute decision making framework for admission of mentally incapable people to care facilities.

It also adds a substitute decision making framework for decisions about personal assistance services (for routine activities of living) for mentally incapable people.

What stays the same in the HCCA?

The HCCA continues to provide comprehensive rules for consent to health treatment in all settings.

It continues to enhance the autonomy of individuals by: allowing people found mentally incapable to have the finding reviewed, allowing incapable people to appoint a representative of their choice to make decisions on their behalf, and requiring that people's treatment wishes that were expressed when the person was mentally capable are to be followed.

The Act also continues to allow the Public Guardian and Trustee to intervene as a last resort substitute decision maker for mentally incapable people.

Where and to whom will the Act apply?

The Act will apply to health treatment that is proposed by health practitioners listed in the Act and in all settings, such as hospitals, clinics, long-term care facilities, health practitioners' offices, or people's homes. The Act will also apply to decisions to admit incapable people to care facilities and, in certain circumstances, to personal assistance services for incapable people receiving such services.

CARE FACILITIES

What is meant by a "care facility" under the HCCA?

A "care facility" means a long-term care facility (nursing home or home for the aged) or another kind of facility set out in regulation as a care facility.

LONG-TERM CARE ADMISSIONS

How does the HCCA apply to admissions to long-term care facilities?

The Act sets out a new substitute decision making framework for admission of incapable people to care facilities (similar to the one for treatment). It provides for substitute decision making; a right of review of incapacity; a provision for crisis admission; and liability protection.

PERSONAL ASSISTANCE SERVICES

What is a "personal assistance service"?

"Personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living.

How does the HCCA apply to decisions about personal assistance services?

The HCCA sets out a new substitute decision making framework for decisions about personal assistance services for incapable recipients of these services (similar to the one for treatment). The application of this part of the HCCA is at the discretion of the service provider. For example, a service provider may choose to use the HCCA to obtain a formal substitute decision where an incapable nursing home resident's routine care is very difficult to manage.

TREATMENT

What is meant by "treatment" under the Act?

As in the CTA, "treatment" has a broad definition in the HCCA: "anything done for a therapeutic, preventive, diagnostic, cosmetic or other health-related purpose". However, more things are excluded than under the CTA, for example, any treatment that in the circumstances poses little or no risk of harm to the person.

The term "treatment" can refer to a single treatment, a course of treatment or a plan of treatment. A plan of treatment is developed by one or more health practitioners and deals with the health problems a person has and may deal with health problems that a person is likely to have in the future. The plan may cover a number of treatments or courses of treatment and may, in addition, deal with the withholding or withdrawal of treatment in light of the person's current health condition.

EXCLUDED ACTS

What is meant by an "excluded act" under the HCCA?

An "excluded act" is an assessment or examination of a person to determine the general nature of the person's condition, a treatment that in the circumstances poses little or no risk of harm to the person, or anything else specified in the regulations as not constituting treatment and set out in the regulations as an "excluded act".

The HCCA allows a health practitioner to "opt in" to the provisions of the Act in order to get a substitute consent for certain things excluded from the definition of treatment ("excluded act"). Where a health practitioner decides to "opt in" to the provisions of the HCCA, the Act and the regulations apply as if the "excluded act" were a treatment.

CONSENT PROCESS

Who can give or refuse consent to a treatment, admission to a care facility or personal assistance services?

A person makes his or her own decision to give or refuse consent if he or she is mentally capable to do so. If a person is mentally incapable of making the required decision, a substitute decision maker, usually a family member or partner, can make the decision.

MENTAL CAPACITY

What is mental capacity?

A person is presumed to be capable of deciding about treatment, admission to a care facility and personal assistance services, unless it is unreasonable to presume so.

A person of any age is capable if the person is able to understand the information about the required decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

How is mental capacity determined?

As in the CTA, when the decision concerns treatment, the health practitioner proposing the treatment determines whether a person is mentally capable of making a decision about the treatment.

When the decision concerns admission to a care facility or personal assistance services, mental capacity is determined by an **"evaluator"** (audiologist, speech-language pathologist, nurse, occupational therapist, physician, physiotherapist, psychologist, or social worker). For example, a nurse who conducts a functional assessment of a prospective long-term care resident could determine whether the person is mentally capable of deciding about the admission.

MULTIDISCIPLINARY TEAMS

How is capacity determined and substitute consent obtained when many health practitioners are involved in a plan of treatment?

If a plan of treatment is proposed, one health practitioner, on behalf of the team, may propose the plan of treatment, determine the person's capacity to consent to the plan. That practitioner may obtain a consent or refusal from the person regarding the treatments in the plan for which the person is capable of consenting, and from the person's substitute decision maker regarding the treatments in the plan for which the person is incapable of consenting.

SUBSTITUTE DECISIONS

Who makes the decision for a person who is mentally incapable of consenting to a proposed treatment, admission to a care facility or personal assistance services? Who has priority?

Most often the substitute decision maker who decides on behalf of an incapable person will be a family member or partner. The HCCA lists possible substitute decision makers in order of priority. The list is similar to the CTA; however, categories have been combined or clarified as follows:

1. court-appointed guardian of the person
2. attorney for personal care
3. Board-appointed representative
4. spouse or partner

5. child or parent (or a Children's Aid Society or other person lawfully entitled in place of parent)
6. parent who only has access
7. brother or sister
8. any other relative (related by blood, marriage or adoption)
9. Public Guardian and Trustee - as a last resort

The HCCA allows any person on the list who is with the incapable person or has been contacted (regardless of where he or she ranks), to make the substitute decision. However, that person must believe that no other person (in an earlier category or the same category) would object to him or her making the decision.

A family member will no longer be required to make a formal statement to become qualified to be a substitute decision maker.

Note that specially-appointed substitute decision makers (categories 1, 2 and 3) have priority over other possible substitute decision makers.

Also note that some people who are incapable to make decisions under the HCCA may still be capable to give a power of attorney for personal care (that is, if they can understand whether the attorney has a genuine concern for their welfare and that the attorney may need to make decisions on their behalf).

Why would someone apply to the Board to be appointed a representative? What is the scope of authority of a Board appointed representative?

If an incapable person has not previously appointed an attorney for personal care and does not have a court-appointed guardian, another person can apply to the Consent and Capacity Board to be appointed his or her representative to make substitute decisions under the HCCA.

The Board has been given broad discretion to give such a representative ongoing authority to make decisions about a treatment or kinds of treatment, or admission to care facilities, or personal assistance services, whenever the person is found incapable of making the decision.

For example, a good friend may become an incapable person's usual substitute decision maker by applying to the Board for appointment as a representative. This helps to keep to a minimum the situations where the Public Guardian and Trustee needs to serve as substitute decision maker, and can avoid the costs and complexity of guardianship for most private individuals.

Relatives or partners of an incapable person do not need to be appointed in order to act as substitute decision makers under the HCCA. However, occasionally, a relative may apply to the Board to seek priority as substitute decision maker over other relatives.

What are the rules for making substitute decisions?

A mentally incapable person may have expressed **wishes** about health treatment, admission to a care facility or personal assistance services when he or she was mentally capable (and at least 16 years old). If the substitute decision maker knows of these wishes, he or she must follow them in giving or refusing consent.

If the substitute decision maker does not know of any wishes or, if it is impossible to follow the wishes, he or she must make the decision based on the incapable person's **best interests.** This includes taking into consideration such things as the person's values and beliefs, current wishes, likely outcomes, risks and benefits, and less restrictive alternatives.

Can a health practitioner question a substitute decision maker's decision?

In an emergency, as under the CTA, treatment may be given despite a refusal by a substitute decision maker, if a health practitioner thinks that the substitute decision maker did not follow the rules for making substitute decisions (wishes, best interests).

When the same kind of concern arises in non-emergency situations under the HCCA, a health practitioner may also question the substitute decision maker's decision, by applying to the Consent and Capacity Board to determine whether the substitute decision maker complied with the rules for making substitute decisions.

CHALLENGING A FINDING OF INCAPACITY

What if a person does not agree that he or she is mentally incapable?

Like the CTA, the HCCA recognizes that finding a person mentally incapable and taking away his or her right to make a decision is a serious matter. A person can apply to the Consent and Capacity Board to have the finding reviewed and may further appeal the Board's decision to the court.

THE CONSENT AND CAPACITY BOARD

What is the Consent and Capacity Board? How can a person contact the Board?

The Consent and Capacity Board is an independent tribunal that holds hearings on application about a number of matters under the HCCA.

A person should contact the regional office of the Board in his or her area. Many facilities and health practitioners will be familiar with the regions of the Board and can supply the address of the appropriate regional office of the Board. As well, people answering the Board's toll free line (1-800-461-2036) will be able to supply the address of the appropriate regional office.

RIGHTS INFORMATION

How will people know about their rights since rights advice has been eliminated under the HCCA?

With respect to a person found incapable of consenting to treatment under the HCCA, health practitioners are required to follow guidelines established by their governing bodies as to information to be provided to their patients about the consequences of findings of treatment incapacity.

There will continue to be rights advisers under the *Mental Health Act* for involuntary admission; incapacity to manage property; incapacity to access or authorize disclosure of one's clinical record; and informal admission of a 12-15 year old.

A new regulation under the *Mental Health Act* will restore rights advice for in-patients of psychiatric facilities found incapable of consenting to treatment of a mental disorder (this was the situation before the CTA).

Information about rights will be given to people who are found incapable of consenting to admission to a long-term care facility, by policy of the Ministry of Health, Long-Term Care Division.

EMERGENCY TREATMENT

Under what circumstances can emergency treatment be given without consent?

As in the CTA, emergency treatment can be given without consent to an incapable person where the health practitioner determines that there is an emergency and the delay in trying to get a substitute decision would prolong the person's suffering or put the person at risk of sustaining serious bodily harm.

The HCCA adds another situation where emergency treatment can be given without consent, that is, where a person is apparently capable but the communication needed to get an informed consent cannot take place because of a language barrier or disability. Steps that are reasonable in the circumstances must be made to find a way for the communication to take place and there must be no reason to believe that the person does not want the treatment.

There is a continuing duty to attempt to locate a substitute decision maker or to find a means of enabling the communication to take place.

FARADIC STIMULATION (electric shock as aversive conditioning)

Why did the government remove the prohibition on substitute decision makers consenting to electric shock as aversive conditioning (faradic stimulation) for incapable people? What safeguards will there be?

It is not the purpose of the HCCA to prejudge whether a particular form of treatment is or is not a good choice in a particular circumstance.

Under the HCCA, if a substitute decision maker consents to the use of faradic stimulation as aversive conditioning, he or she is accountable for deciding in accordance with the usual criteria regarding the incapable person's wishes and best interests.

A new regulation under the *Regulated Health Professions Act* makes faradic stimulation a controlled act that can only be ordered by physicians and psychologists, and be performed only on their order and under their direction.

Physicians and psychologists must adhere to the standards of practice of their profession.

TRANSITION

What will happen to processes started under the old CTA?

The HCCA will only apply to treatment which starts after the day the HCCA comes into force.

The HCCA will not apply to people already on a waiting list for admission to a long-term care facility on or before the day the HCCA comes into force.

Hearings or appeals begun before the HCCA comes into force can be continued under the transitional rules.

PUBLIC AND HEALTH CARE PROVIDER INFORMATION

How can the public and health care practitioners and service providers get more information about this legislation?

The Ministry of Health's Information Centre has a toll-free line (1-800-461-2036) for people to call and ask questions and to request further information about the *Health Care Consent Act, 1996*.